This...Is Augusta

By AUGUSTA SUGGS

Most students, and, in fact, most faculty members here at MCG, never see most of Augusta. Common reasons given for not exploring the off-campus aspects of the Garden City are: "It's raining too hard to see out of my car," or "I've got to pass my boards two years from now, so I can't take this afternoon off."

It is my hope that in writing this article, the students and faculty will come to understand and appreciate the city, and cease to think of it as merely a disgusting conglomeration of larcenous old ladies and pot-bellied cops.

A BRIEF HISTORY OF THE PLACE

Augusta was founded by FRANCISCO AGUSKY, the only truly great Polish colonizer and explorer. In fact, it was by mere accident that Agusky founded the city, having been swept up the Savannah river by a weird series of retrograde sewage waves from the Atlantic. Upon landing Agusky proclaimed "Czeclena nordio szlecava" which, of course, is Augusta's fundamental credo.

Actually, Czeclena nordio szlecava does not mean "I've found the Garden City," but actually means "This is a low point for Polish civilization."

A GENERAL LOOK AT THE TOPOGRAPHY AND CLIMATE

There are two general sections of Augusta: the "hill" and "non-hill." The famous Augusta "hill" is actually the very last nub, or left-over, of that part of the earth which was not needed to create the Appalachians. Because of the extreme age of "the hill," centuries of water run-off have created numerous huge gulleys and pits, and it is over these pits that we today ride in our cars and buses. The largest of these ancient stream beds is now known as Broad Street.

The climate of Augusta is one of its most unique features. It rains in...
Augusta an average of 6800 times per year. In fact, it is said that The Great Augusta Fire, which destroyed literally thousands of fake ante bellum mansions in 1927, was the direct result of a drought which occurred in July of that year. After going for four straight days without being rained on, eyewitnesses reported that the streets and plants burst into spontaneous combustion. Meteorologists also report to Augusta as the great drying place of aberrant weather patterns. It is said only half-jokingly that Augusta is where hurricanes come to die.

ENTERTAINMENT
It is a general complaint of students at MCG that there is nothing to do here, This is simply not the case. There are several local nightclubs which offer the finest in talent, the best of food, and some of the best chances to meet a genuine cross section of enlisted men from this country and beyond. Silverware, glasses and chairs are the only items for which some clubs charge extra, capacity most clubs runs around 150, but up to 900 are usually accommodated.

Augusta has three television stations, two of which are usually accommodated on the air most of the week. The two newspapers in Augusta are known statewide for their objective reporting, broad spectrum of opinion and the fact that both cost a nickel more than the inferior Atlanta papers. Radio also exists in Augusta, and a particularly well-run station is WACG-FM, Augusta College Radio, replete with its professional quality of announcers and its non-stop, no-gap programming.

RELIGIOUS LIFE
There are 854 churches in Augusta. All major denominations are represented, and the Michael Guido Tabernacle of Interplanetary Communication is known world-wide for its past efforts to provide bibles to thousands of starving children in Biafra and Nicaragua (the fact that this dream is not realized may be another indication of the despairing state of our times).

HOUSING
Of all the attractive aspects of Augusta, perhaps the most pleasing is the wonderful abundance of clean, economical housing available to the MCG student. It is almost as if the entire population of the C.S.R.A. decided to make a concerted effort to welcome MCG students and attempt to keep them in the area for a lifetime. It is not uncommon to find apartment complexes with two and three bedroom “suites and townhouses,” complete with rugs and running water, renting for under $250 (electricity, heat, air-conditioning, locks, parking space, TV antenna outlets, and mirrors sometimes extra).

If one is turned off by the “certain pigeon-coup” atmosphere of an apartment complex, there are hoards of “hill-ladies” who graciously make available their unused attics, basements, closets and garages for entirely reasonable rates. The charming Gothic atmosphere of most of these places is enhanced by the gas-lighting and “European temperature climate control” provided by these gracious hosts, and is only an additional enhancement.

Health Manpower Legislation
Many of you received a copy of the Report of the Task Force on Health Manpower during the last month. The status of the legislation as of this writing points to some sort of action by the House and/or Senate by the end of April. There are presently two Health Manpower bills in the House Public Health and Environment Subcommittee – one that was passed by the House before it adjourned in December, and another that was written by the Task Force on Health Manpower of the American Association of Medical Colleges. The Senate Health Subcommittee has not yet scheduled hearings on health manpower-legislation, but it is expected that bills written by Senator Edward Kennedy and by the Task Force on Health Manpower will be submitted by the end of March.

It is extremely important that medical students here at MCG and all over the nation be concerned and informed about the legislation on Health Manpower, not so much for ourselves, as for the classes of the near future. They are the ones who will catch the brunt of increased tuition (up to 300% higher than present rates), mandatory service in shortage areas, and decreased numbers of residency positions.

FLORA AND FAUNA
One often hears stories of such malicious happenings as roaches carrying off canned goods and eating small children in the dead of night in Augusta. In fact, it is only the INSECTA TALMA GUM ROACHARIA that has been known to attack humans, and this rare species inhabits only the ETMH cafeteria storage room.

The primary plant life in Augusta is the rare PRIVATICUS SOLITARIUS, a thick clinging vine found surrounding any object or beauty or of historical interest in the city. Unfortunately, the vine is of a somewhat stubborn breed, and several 300 year old rare Augusta oak trees have been strangled within a period of several hours.

CONCLUSION
Now that you know more about THE GARDEN SPOT OF THE SOUTH, perhaps you will not be as afraid to invite your parents or friends to the city for a good old Augusta weekend. Be honest now. Is Augusta really that disgusting? Is Augusta really a scum-bag, hell-hole, piece of slag that should be target zero for a Russian sneak attack? The answer is a resounding NO! A Chinese platoon attack (three hoards and a bugle) with conventional weapons, however, might merit some consideration.

BETTER READ THIS...
By GERALD STATON

1. Material covered by the Act as “education records” is recorded information related to the student maintained by the school or one of its agents used for making decisions about the student, or which may be transmitted to others outside of the institution.

2. Students may not see confidential letters or statements of recommendation submitted in confidence for school records prior to January 1, 1975, provided they are not used for other than the original intended purpose. Further, students may waive the right of access to future confidential recommendations in the area of admission, job placement and receipt of awards. However, the waiver may not be required as a condition for admission, financial aid or other services, and the student must be notified of the name of every person submitting confidential recommendation whether these are solicited by the institution or the student, or are submitted on the initiative of the evaluator.

3. Private notes and materials designed as personal memory aids are not covered provided they are not made available to anyone else except a substitute teacher or counsellor who would

(Continued on page 7)
To the editor:

Thanks ever so much for the centerfold which appeared in the March issue of the CADAVER. I came just in time since my subscription for PLAYGIRL ran out this month. It was also very nice of you guys to remember us nursing students in such a way. But remember we aren't the only females on campus. Some of the other female students may have felt left out because you addressed the centerfold to us and for our enjoyment. So maybe the next centerfold should be addressed to all female students!

If I may I would like to make a few recommendations for your next centerfold. Why not find a guy with a little more hair on those places you chose to hide with cats. Maybe next time you should use a nice long snake, too. And as for the location, why not let the next centerfold be sprawled out in front of Residence II on the steps where everyone can see!

Sincerely,

A sophomore nursing student who likes the CADAVER

We dusted for fingerprints and Dave will be by late some evening soon to discuss that canard about his hair distribution. Would you, as a budding herpetologist, care to elaborate further on the issue of cats vs. snakes?—(Ed.)

Dear Mr. Pratt,

I am one student who never gets a copy of the CADAVER. I had assumed this was because there were not enough to go around. But Monday, I was in the Student Center and noticed a box of中心fold—perhaps 50 copies—on the Student Council office. Why aren’t these distributed? I have yet to see a single one of them. If I may I would like to suggest that the centerfold be distributed not only to the student body but also to the faculty and staff. I think it would be very interesting and informative for them to see what is going on in the Student Center.

Sincerely,

An interested reader

Dear Mr. Pratt,

Thanks for your letter. I am sorry to hear that you do not receive a copy of the CADAVER. It is unfortunate that the distribution scheme must not be expanded to tens of millions of American urban planners. If there had been banks in this country instead of 1st century Rome, he no doubt would have become an urban planner; and victims of his paranoia and incompetence would have expanded to tens of millions of urbanites, stifling in their own effluvium, rather than a few thousand Romans.

Sincerely,

Daniel M. Strickland, Medical Student
Medical College of Georgia, Augusta

TO: Frank Pratt

"CADAVER" Circulation

For the past two months the Department of Anatomy has not received their copies of your very interesting publication, the CADAVER. The absence of your publication has prompted many inquiries from our faculty and staff. Please see that we are placed on your list for the next few months and also that we receive the current copy for March.

Thank you very much,

/S/ Joan G. Lowery
Secretary to the Chairman
Department of Anatomy

Until the mailroom resumes helping us with distribution, we’ll deliver copies via the Library and the Student Center.—(Ed.)

Sir,

I should like to protest the recent proliferation of signs in the Rack Building.

Back in September, when I still harbored such cherished beliefs as, “once you get into med school, the competition’s over,” I would quest after 2:32 for hours at a time, and many an upperclassperson had the pleasure of misdirecting me down yet another false corridor. Am I to be denied this small pleasure? Are the incoming freshmen to be able to find their own way?

Looks like I have been growing. (Ed.)

Pierre de Vise, Urban Planner
University of Illinois, Chicago Circle

As quoted in Online, Vol. 3, No. 1, Feb. 1975

"Status epilepticus, priapism, and predation, not necessarily in that order, are the three major cachets of American urban planners. If Nero had been born in this country instead of Austria, he no doubt would have become a doctor, and victims of his sadism and thirst for personal power would have been limited to a few hundred patients rather than tens of millions."

Dear Frank:

Thanks for reprinting the Illich article. It is Doc. 1/74/62 from the Centro Intercultural De Documentación (CIDOC), APDO. 479, Cuernavaca, Mexico, CIDOC, according to their catalog No. 20.

Please let me know when the catalog is welcome to drop by my office (CB-3D2-251-60-4957).

CIDOC has prepared an extensive anthology on medicine which emphasizes alternatives in health care and limits of therapy. I have requested its purchase for the HSU library. No doubt the anthology will provide some interesting perspectives on medicine, health care and societal roles for physicians.

Please understand that my calling attention to Illich’s article and CIDOC is not to be taken as a personal endorsement. The objective is to juggle a few neurons, to trigger patterns of neural activity consonant with a somewhat broader perspective than appears to be promulgated in the immediate environment. Remember Coghill’s warning: "when new turns in behavior cease to appear in the life of the individual its behavior ceases to be intelligent." (Coghill, G.E., Anatomy and the Problem of Behavior, 1929.)

Best regards,

/S/ S. David Stoney, Jr., Ph.D. Associate Professor

Thanks for the clarification, Dave. We aren’t fanned to a white heat by allegedly razor-thin perspectives on health delivery because we feel enough crap has been published elsewhere to broaden everyone.—(Ed.)
The Medical School Bottleneck Must End

By JOAN BECK – Reprinted from CHICAGO TRIBUNE – Friday, March 14, 1975

On any given day this March, thousands of anxious, tired college seniors will be filling the campus post box for letters of acceptance or rejection to medical school. Most of the letters will be rejections, for there are fewer than 15,000 places in first-year classes in United States medical and dental schools and if last year is any indication, at least 40,000 students will have more than 320,000 applications for those openings. Two applicants in every three won't get in anywhere, after investing four years in pre-med education.

On any given day this March, hard-pressed physicians will be working 12 to 14 hours a day and telling their secretaries not to book any more patients until June, except in emergencies. Worried mothers with feverish kids will not be able to get a doctor to make a house call. Inner city residents will be taking numbers and waiting hours in a hospital emergency clinic for a chance to see a physician.

In a country that urgently needs physicians to keep up with rising expectations for quality medical care, the medical school bottleneck has become intolerable. A majority of young men and women who want to become doctors can't get the training they need. Millions of people suffer from a lack of adequate access to physicians, despite Medicare and Medicaid. Medical schools are graduating only half enough students to fill available internships and residencies. And, unconsciously, the United States is draining physicians away from other countries in increasing numbers to fill its needs, regardless of their generally poor performance on licensing exams and the difficulties in communication involved.

As usual, the American Medical Association insists it is doing all that can be done to boost the supply of physicians. It points out that the number of medical colleges in the United States has grown from 86 to 114 in the last 10 years, that two new schools of medicine will open this fall and three more in 1976. It laments the lack of more federal funds, the difficulties in finding full-time med school faculty members [more than 2,000 budgeted jobs were unfilled last year], and the immigration of foreign physicians from countries whose need for doctors is acute.

But, says the A.M.A., it's all the fault of the general public's failing to provide support for the med schools.

What the public should do, then, is to insist – thru state legislatures if necessary – that existing medical schools expand at an accelerated rate and that many more be started as quickly as possible. [Some lessons from the stepped-up graduate training programs during World War II may be applicable.]

Alternate routes to the M.D. degree should also be explored, so that research-minded pre-meds and med students can follow a heavily scientific curriculum while those who intend to become family doctors might short-cut some of the chemistry and math.

The new young Albert Schweitzers don't always survive the grueling competition in calculus and organic chemistry as undergraduates.

And the competition truly is fierce. The number of applications to medical schools has jumped 130 per cent in the last 10 years. Some top colleges of medicine now have 50 applicants for every opening and a few could fill their entire first year classes if all applicants who already have a Ph.D.

With a talent pool of bright young people almost desperately eager to go into medicine – and with an urgent, life-or-death need for more physicians – it makes no sense whatsoever to tolerate the medical school bottleneck.

The Aroma Of Sex

By ROBERT B. GREENBLATT, M.D.

As a medical student, some 45 years ago, I first learned that the sense of the general palate, a condition in the nose was at times employed successfully for the treatment of essential or primary dysmenorrhea. Later, I found that estrogen administration was recommended for the treatment of obesity and a condition of dryness and crust formation of the nasal mucosa. It was not until 1944 that a relationship between eunuchoidism and the olfactory apparatus was established by Kallman. In 1964, Morrier and Gauthier named the syndrome "olfacto-genital dysplasia." In the past decade, several reports of diminution or loss of smell, in association with either hypovarianism or hypogonadism, have appeared (Netter et al., Marshall and Henkin, Mrouch and Kase). Having encountered three such cases in the past year, the essayist is prompted to review the relevance of smell to gonadal function.

Olfaction in mammalian reproduction is an intriguing chapter in sexual physiology. The role which odors play in human responses can be summarized in the universal use of perfumes that serve to tantalize, allure and incite. Two odorous substances produce by the vaginal secretions of some species the male may identify and mount them if they attract him. Dogs sniff more frequently at a strange animal of either sex by sniffing the anogenital region. An estrous female provokes a stronger sniffing and licking response by the male. Furthermore, castration reduces a male rat's ability to discriminate sexual odors. Thus, the nasal mucosa and the olfactory epithelium appear to be influenced by hormones.

It would seem that olfaction plays an important role in sexual identification and arousal and that loss of olfactory sensations might result in at least a diminution in mating activity, particularly in the male. Anosmia has been shown in some cases to result in a decrease of male copulatory behavior. Anosmia in mice can affect ovarian activity and mating behavior; removal of olfactory bulbs in mice induces uterine and ovarian atrophy with loss of estrous cycles in certain strains (Whitten). This is similar to anosmic females with primary amenorrhea, while other anosmic females may merely suffer from oligomenorrhea or may have no menstrual disorder.

The five senses play a role in sexual behavior in mammals. In some species the male may identify an estrous female by visual cues, i.e., the color of her hind-end. The male may respond to sound, such as the mating call, or to identifying odors. Chemicals from the vagina, the urine, or the cutaneous glands may all convey the same message.

In the human, the disorder known as Kallmann's syndrome is characterized by hypogonadism in association with anosmia or hyposmia. The gonadotropin deficiency may be due to a developmental anomaly in the hypothalamus or contiguous olfactory lobes. The syndrome was first reported in eunuchoidal males, but many instances of its occurrence in amenorrheic females are now on record. Failure of the pituitary to secrete gonadotropins, i.e., follicle stimulating hormone (FSH) and luteinizing hormone (LH), and interference with smell and taste sensation by a distinctive feature. It now appears that smell, hormones, sex, and reproduction are perplexingly entangled. Of the five senses that play a role in behavioral responses, sight and touch are of most importance to the human, while smell is most important in some other animals of the mammalian species. In these, pheromones (substances produced by one member of a species and odors are intimately associated with sexual rewards.

ENDOCRINE INFLUENCES ON PHEROMONE PRODUCTION

Females produce odorous substances that are attractive to males during the follicular phase of their cycles. Male dogs with adrenal or testicular (Sertoli-cell) tumors secreting estrogens attract male dogs in a manner similar to that of an estrous bitch. Many male mammals exhibit an intense characteristic odor dependent on testicular function. These odors are lost after castration. Rams normally ignore pregnant females, but will be attracted and mount them if they are anointed with vaginal secretions from estrous ewes (Kelly). Recently, Michael and Keverne have shown that a substance produced in the vagina of rhesus monkeys, by the local action of estradiol, which stimulates sexual activity of males. They concluded that estrogen-stimulated vaginal secretions contain a pheromone which excites males and leads to overt sexual behavior. Temporary anosmia, produced by plugging the nasal passages with bismuth-iodoform impregnated gauze, eliminated much of the response, Murphy and Schneider observed that if the secretions from a sexually stimulated estrous hamster are applied to a male, other males will attempt to copulate with him. Dogs sniff more frequently at cotton balls that have been used to swear the vulva of untreated castrate females (Beard and Mereri). Male dogs frequently investigate a strange animal of either sex by sniffing the anogenital region. An estrous female provokes a stronger sniffing and licking response by the male. Furthermore, castration reduces a male rat's ability to discriminate sexual odors. Thus, the nasal mucosa and the olfactory epithelium appear to be influenced by hormones.
A Systematic Approach To Teaching

By LLOYD A. LEWIS

Improved teaching is a primary concern of the MCG faculty, students, and administrators. Faculty try to bring about improvements by using innovations. Students try to bring about improvements by complaining. Administrators frequently try to promote good teaching by adding more faculty or by spending more money on teaching materials. I am convinced, however, that trying innovations, adding more teachers, spending more money, and complaining, by themselves, will not substantially improve the quality of teaching and learning. Although these steps may improve the learning-environment somewhat, I firmly believe what is needed is a more effective teaching approach. The teaching system I am presenting here is not a panacea. However, there is evidence that if this system, or another similar system, is put into regular classroom practice, learning will increase substantially, and students will be more empathetic to teaching problems.

The system which I am presenting is an adaptation of one used in many areas of education. Arsham, Colenbrander, and Spivey* have used a slightly different version to develop and teach medical skills. In their study, a systematic approach was used to teach sophomore medical students a unit on ophthalmoscopy. They were compared to senior medical students who were taught by traditional methods. Approximately two-thirds of the sophomores scored higher than the best senior. None of the sophomores scored as low as the poorest senior.

I call this system a Diagnostic Teaching Model. It is diagnostic in that it allows a teacher, with student help, to diagnose student learning problems as well as deficiencies in instructional methods, materials, and evaluation. In other words, teaching since it entails the functions a teacher must provide to insure learning. It is a model in that it provides a pattern for systematic teaching.

The model has four main components: (1) instructional objectives; (2) prerequisites; (3) evaluation procedures; and (4) instructional methods. It can be visualized in the following diagram:

![Diagnostic Teaching Model Diagram]

Instructional objectives state what a learner is expected to be able to do at the end of a learning experience. Prerequisites are those skills, attitudes, and knowledge which a student must already possess to satisfactorily start a learning experience. As can be seen from the diagram, instructional objectives (hereafter called objectives) and the prerequisites are specified concurrently. Theoretically, prerequisites cannot be identified until one knows what is going to be taught, i.e., objectives. In practice, objectives are not written without keeping necessary background skills in mind. Since students do not always have the desired prerequisites, it may be necessary to teach those skills and knowledge in the objectives. The level of preparedness of students may vary from year to year; therefore, objectives must be adjusted to take this into consideration. An instructor cannot be sure that students have these preliminary skills and knowledge unless he tests the students diagnostically. If some students do not possess these skills, they must be given individual help. If many students do not possess these skills, then the teacher must teach the prerequisites to the class as a whole, perhaps by using self-instructional materials. In short, objectives and prerequisites cannot be considered independently of each other.

Space does not permit discussion of some very important issues about objectives: (1) how objectives can be written unambiguously; (2) how objectives are written for appropriate levels of learning, i.e., factual knowledge, problem solving, etc.; (3) how the most important objectives are selected; and (4) how diagnostic tests are designed and interpreted. The most important issue is that an instructor must establish clear objectives for the students.

After objectives and prerequisites have been written, evaluation procedures should be established. Each item in a given examination should be directly related to one or more statements in the objectives. Tests are valid only if test items are a representative sample of the skills and knowledge specified by the objectives. Teachers should adopt a systematic method for relating test items to objectives; nonsystematic methods frequently lead to two types of invalidity. In one case, an instructor may write test items for which there are no objectives. In the other case, he may have objectives for which he does not write test items. Both cases lead to an inaccurate assessment of student achievement.

Evaluation processes should also include student reactions to teaching and evaluation procedures. Only students can best present the students' points of view. A well-designed course questionnaire conscientiously completed by the class can identify needed modifications that may enhance teaching and learning. However, the questionnaire information must not be considered by itself but in other data in order to design the course such as student performance and student-teacher interaction data.

Instructional methods are not selected until all other components are determined since the other components help to indicate which instructional methods are most likely to lead to successful learning. For example, if an objective is for a student to learn to identify tissues using a microscope and histology slides, then practice with a microscope and slides and not reading descriptions in a textbook may be the most effective means of achieving the objective. Some people prefer to select instructional procedures before determining evaluation procedures since in the classroom they teach before they test. I have no real quarrel with this except that designing tests after writing objectives is less likely to insure a high correspondence between objectives and test items.

The model is more than the sum of its parts; the interactions between components as well as the adequacy of the individual components must be examined when it is used in the classroom. An accurate picture of the model cannot be obtained unless sufficient information is obtained about the interactions. For example, the effectiveness of instructional materials depends on adequate assessment without examining student performance and course evaluation data. This implies there must be satisfactory rapport between students and teachers as well as continuous interaction between them. Information gained from assessment of one trial of the model serves as a basis for revision of an instructional unit before it is taught again. In order to evaluate the effect of revisions on learning, times revisions of an instructional unit must be compared. If comparisons are not made, the model cannot be said to be fully implemented and may not produce any better student performance than less systematic teaching methods.

In order for the system to function correctly, students should be given the course objectives from the beginning. Then, as the course proceeds, students need detailed feedback indicating which objectives they have and have not mastered. At the end of a unit, students must provide feedback to the teacher. Of course, they must have the objectives as a basis for making worthwhile comments. Well written objectives also allow students to use their study time more effectively than otherwise. Many instructors believe grades can be used as feedback mechanisms; this is not true since grades do not provide enough information.

Teachers who have adopted this type of a systematic approach find that the nature of their roles change; it shifts from an imparter of information to a manager of resources. Teachers find that communicating with their colleagues is also important. For example, two instructors, one of whose course precedes the other's course, can pinpoint whether their objectives overlap usefully, needlessly, or not at all. Instructors who collaborate in teaching the same course find their efforts are simplified and made more effective.

The chief disadvantage of this model is that it requires a considerable amount of work to write objectives, it requires effective student evaluation procedures, devise course evaluation procedures, and make revisions of teaching methods. Because of the time involved, this model should not be adopted for an entire course at one time but rather it should be applied to smaller instructional units of two or three weeks in length. However, for each instructional unit the model should be implemented in its entirety. This type of implementation is advantageous because the instructor makes his initial misjudgments on small units. Thus he can learn how to implement the model without investing an overwhelming amount of work. From the course and student evaluation, he finds out whether or not the changes adopted actually improve student performance and morale. Students tend to become proponents rather than opponents of the teacher in this situation.

In the foregoing account, I have discussed a systematic approach to instruction and its benefits to the teacher and learner. The final point I want to express my appreciation to Dr. Thomas McDonald for his very helpful suggestions in revising this article.

Editor's Note: As skyrocketing inflation and the ever increasing costs of living persist, many medical students, married and single, find they can no longer make budgetary ends meet. For some, mounting debts and yearly "loan rounds" have become depressing and tiresome.

The Problem: Money. The Answer: The Military? For many students, the new money-lined programs of the Armed Services and the Public Health Service have solved present financial woes in lieu of future government service.

Dr. George Baker forwards the following article to Vital Signs. Written by Dr. David Tormey, the Dean of Students at the University of Arizona, and Public Health programs of the Armed Services and PHS, Dr. Tormey frankly discusses the ultimate purpose of these programs. His discussion should be of help to any student considering the uniformed services.

Also, in a letter which follows below, Dr. Kim Comstock, a 1974 U of I graduate now with the PHS in Tuba City, Arizona, expresses some frustrations with the service which he feels the student body should be made aware. Dr. Baker's response is also printed below.

The following is the product of a one-day series of meetings in Washington in September with representatives of the Army, Navy, Air Force, and Public Health Service, plus additional input via follow-up letters and phone calls. The comments, impressions and conclusions are the author's and do not represent the official position of the uniformed services.

Bonuses Babies

Now that there is no longer an operational Doctor Draft, all four services are taking a very realistic viewpoint in terms of both recruitment and retention. The single and most important addition to their armamentarium in this regard is the recent pay bonus legislation which, for the first time, permits the uniformed services to realistically compete with civilian practice. As a quick example of what this new bonus means is the fact that three months ago a young physician coming into the Public Health Service for two years of service on an Indian Reservation received an overall salary of $17,000 per annum. With this bonus the salary now jumps to $29,000.

One Generalization

Before getting into the specifics of the various programs, I think there is one generalization which came out of my conversations with representatives of each service. That is, the principal thrust of the three Armed Services is recruitment and channeling of the young physician toward their graduate medical education program - to insure that needed manpower is available in the future. It is important to remember that input via the Berry Plan will, for all intents and purposes, end in July of 1976. On the other hand, the Public Health Service, particularly the Health Services Branch of the National Health Service Corps, is interested in recruiting physicians to deliver primary care, either fully trained (family practice, internal medicine or pediatrics) or directly where they need. Neither the Public Health Service nor the Indian Health Service has any interest in replacing specialists.

The Programs

There is such a commonality of policies, programs, etc., for the three Armed Services that I feel it is sensible to present them together as we look at their two programs that have significant interest for GSA and its constituency. Those are the Health Professional Scholarship Programs (HPSP) and their Graduate Medical Education Program (GMEP).

The following graph [Fig. 1] touches upon some of the high points of the Scholarship Program. The immediate or projected need of the Armed Services, particularly in respect to clinical disciplines, must be the final decision-maker as to whether or not a particular scholarship holder can have his "druthers" in respect to residency training. For example, if Joe Blow has been a scholarship holder with the Navy and at the time of graduation he indicates a career plan in neurosurgery, the Navy will necessarily take a look at whether they need another neurosurgeon six or seven years hence regardless of whether Joe Blow takes his training in or out of the Navy. If the need for such a specialist cannot be foreseen, then Dr. Blow will be encouraged to help the Navy to follow some other specialty route which they have a projected need for; or if he cannot be dissuaded from neurosurgery, then they will bring him on duty as a general surgeon. This method will be used in the ensuing years of pay-back time they can justify neurosurgical training for him or he may in time change his own mind for another specialty. What this, of course, represents is the Service building a training program based not upon whim and individual fancy but rather justified need, their need. As a primary service they have a responsibility to place the scholarship holder immediately into residency training is based upon the lack of predicted need in that particular specialty for that particular year of completion of training. In other considerations such as training capability, quality of the applicant, staffing requirements here and abroad, etc. However, all of these are subject to change and thus the predictions will have to change and here is where the Indian Health Service finds they are extremely hopeful in this regard. In addition, they have taken positive efforts toward stabilizing tours of duty (the average is now at least four years) and, of course, without any war going on hardship tours are a relative rarity - probably one such in a twenty-year tour.

The following graph [Fig. 2] highlights the Graduate Medical Education Program of the Armed Forces.

As far as the Public Health Service is concerned I found a lot of new activity going on and a good deal of positive enthusiasm for their role in national health care. It is very obvious that the mood in Congress is to do something about the distribution of physicians, both geographically and discipline-wise, and here is where the Indian Health Service and the National Health Service Corps take on real meaning. PHS is presently monitoring two scholarship programs, their own Scholarship Program and the Physician Shortage Area Scholarship Program. The key points of these are as follows:

As I indicated earlier, PHS has more immediate need for primary care physicians whereas the other services have more pressing need in the future. For this reason, PHS has given the green light for such programs. They appear to be of considerable interest to the selective services and they would probably be given the green light for such training with the pay-back to come two or three years later, being utilized as a qualified specialist.

Both Indian Health and NHSC would really prefer to get people who have finished their training in one of the three primary care disciplines, with the anticipation that there would then be a greater likelihood that they might stay with IHS or the rural community that NHSC has placed them in as opposed to leaving after two or three years to get residency training.

Health Corps Smokin'

Apart from the Public Health Service Scholarship Program, the National Health Service Corps needs to find its market. As it can be seen, it is also the Indian Health Service, in their recruitment efforts aimed at young house officers either after the first year of postgraduate training or, preferably, after

(Continued on page 7)
residency training has been completed in a primary care discipline. The financial inducements are significant; $30,000 per year plus PHS gets benefits of new pay bonus as well as Armed Forces), thirty days leave, moving expenses, Selective Service obligation fulfilled, GI benefits for future residency training ($250-$350 per month for three years -- after two years of service) and finally, qualification for the loan forgiveness program (see below).

The Perfect Match

NHSC has a very interesting system of trying very hard to match the doctor with his community. They do it through a computer and it sounds very much like a dating agency. "The doctor and spouse pick a variety of preferences, the communities do the same and the computer spits out the match. NHSC then will fund the doctor traveling to at least one of these communities after the two or three -- year obligation is up. Their success rate in this regard is very encouraging: the first year of the program they had an overall retention rate of three per cent, last year it jumped to twenty per cent and they are now projecting thirty per cent for next year. The facilities that these physicians practice in have all been set up and equipped by the community and in many instances the community has made other efforts toward wooing the physician in terms of housing, etc. There is a good deal of optimism about this program particularly as PHS senses strong and growing stronger Congressional support for this national program.

Indians Winning

The same sort of optimism is obviously pervading the Indian Health Service. Congress at long last is beginning to recognize the needs of the American Indian and many, many more dollars are flowing in that direction than heretofore. IHS operates fifty-one hospitals and seventy-seven health centers, almost all of which are located in rural areas west of the Mississippi, including Alaska. As with NHSC, these situations almost exclusively need primary physicians; and when other specialties are called for, contracts and arrangements have been set up with nearby civilian physicians. IHS admits that some of their locales are "hardships" in terms of a concert hall or an art museum but if the doctor is truly committed to live in some of the most beautiful parts of America and like to hunt, fish, backpack, etc., then IHS can meet their needs.

Debts Disappear

One of the most intriguing new programs that I encountered is the loan forgiveness program. This is only available to physicians in the Public Health Service -- not the Armed Forces. What it consists of is if one serves at a Corps site for a minimum of two consecutive years one can qualify to receive repayment of sixty per cent of educational loans incurred in medical school. This is all inclusive, i.e., Federal loans, bank loans, private loans, etc. If the doctor agrees to remain for a third year on, for instance, an Indian Reservation or a National Health Service Corps site, then an additional twenty-five per cent of the loan will be repaid by the Federal government. I asked the question whether scholarship holders who got dollar "goodies" during medical school could also qualify for this loan forgiveness program once they went on active duty and the message I got was that this was still under study but there was good indication that this might well be the case.

Military Medical School

Finally, the newest "action" within the uniformed services is their Uniformed Services University of the Health Sciences. This is essentially a medical school which in time will be built adjacent to the Bethesda Naval Hospital, across the street from NIH and has a Congressional mandate to graduate a minimum class of one hundred by 1982. They are in the process of recruiting a dean and basic science faculty and might well be in a position to begin to recruit a small number of students (twenty-four to thirty-six) if not for the fall of 1975 then certainly for the fall of 1976. Very clearly this school in no way has been set up to meet the manpower needs of the uniformed services but I gather that it will serve as an excellent nidus for a continuum of medical education within the four uniformed services.

In summary, my brief visit to Washington convinced me that the uniformed services are alive and well and very anxious for GSA to learn more about their goals and programs.

...ARMED FORCES & MED STUDENT...

ARMED FORCES HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

<table>
<thead>
<tr>
<th># Scholarships</th>
<th>Total (Maximum available)</th>
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<th>NAVY</th>
<th>AIR FORCE</th>
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<td>Number</td>
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<td>Class '75-'76</td>
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<td>76-76</td>
<td>76-76</td>
<td>76-76</td>
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<td>Next Year</td>
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<td>Class '77-'78</td>
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<td>2:1</td>
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<tr>
<td>Five Year Projection</td>
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<td>Stable</td>
<td>Stable</td>
</tr>
<tr>
<td>Residency training immediately after internship</td>
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<td>605</td>
<td>655</td>
<td>75-865</td>
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<tr>
<td>Civilian residency at the military hospital</td>
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<td>Reasonable</td>
<td>Substantial</td>
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<tr>
<td>Commitment</td>
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<td>One-year or Two-year tuition during last year of resident</td>
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<td>Same</td>
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<tr>
<td>Benefits</td>
<td></td>
<td>Tuition, fees and books of $1000-3000</td>
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ARMED FORCES GRADUATE MEDICAL EDUCATION PROGRAM

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<td>First year spaces</td>
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<td>Five-year projection</td>
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<td>Quality</td>
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<tr>
<td>Commitment</td>
<td>Two years after training</td>
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<tr>
<td>Benefits</td>
<td>Salary $13-$15,500</td>
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</tbody>
</table>

R.B. It is my understanding that the new pay bonus is not applicable during residency training or to the pay-back time incurred by scholarship holders. The regulations indicate that you can have just been issued -- particulars are still in a state of flux.

...BETTER READ THIS...

[Figure 1]

Reprinted from VITAL SIGNS -- University of Iowa

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states in the area of malpractice liability insurance. The cost of insurance in 20 states rose from 100% to 606% over last year. The largest rate increase is in Ohio, where premiums were up 423% for Class I (low risk) M.D.'s and 747% for Class V (highest risk) M.D.'s. In five states, insurance companies are refusing to write new policies and are pulling out entirely from high risk areas and specialties.

The situation in Georgia is not as bad as the national picture with only 25% increases over last year. The current rates in Georgia are $285/yr from $1530/yr for Class V. From 96% to 98% of the physicians in Georgia are covered through a Medical Association of Georgia group policy.

...SENIO RS MATCH...